201 Interpersonal Relationships

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Definition

Interpersonal relationships refer to reciprocal social and emotional interactions between the patient and other persons in the environment. Almost every mental disorder is accompanied by problems in this respect. Frequently a basic cause of conflict with other people is the presence of some psychiatric disorder. Major areas in which these conflicts may occur include the following relations:

- Family
- Social
- Work
- Religious
- Sexual

Technique

Family Relationships

Family relationships include those both with the spouse and with other relatives. Inquiry into these relationships usually begins with investigation of the marital relationship. Marital conflicts are often quite subtle. Patients frequently fail to see a connection between their presenting symptomatology and their marital disharmony, particularly when the presenting problem is a psychophysiologic one such as asthma or peptic ulcer. At times the patient is unconsciously resisting seeing such a connection out of fear that exploration of the conflicts might lead to dissolution of the marriage.

It is often useful to start with open-ended general questions or statements, such as: "Tell me about your marriage. What is your marriage like?" The degree of warmth and enthusiasm with which the patient describes the marriage may be more important than the actual words. At times patients may say that the marriage is fine even when it is not because they feel uncomfortable in discussing the difficulties that are present. If anything in the patient's response indicates that there may be difficulties within the marriage, proceed to more detailed questioning. Asking the patient to describe the spouse is often a helpful beginning. If the patient lists no shortcomings of the spouse, this can be pointed out and the patient encouraged to describe even minor things that might be annoying. Even in the best of marriages there are bound to be attributes of the spouse that are somewhat irritating to the other member of the pair. If the patient indicates in some fashion that there are serious difficulties but becomes uncomfortable when inquiry is made into these areas, it is usually wise to avoid pressing the patient strongly in the initial history-gathering process. If strongly pressed, many patients will begin to deny difficulties. This will make later therapy more difficult, since the patient will eventually have to admit having misled you if you are to help him or her with these problems.

If the patient is comfortable with describing the marital problems in detail, this should be pursued fully. The patient should be asked to describe the nature of the conflicts, feelings about the conflicts, and efforts at resolution. In gathering this information, the physician often gains important information concerning the patient's flexibility, assertiveness, independence, and insight.

In addition, the examiner should seek information about the interaction of the patient and other significant family members, particularly children and parents. Most patients do not feel threatened by direct inquiry concerning their children or parents.

If the patient's children are young, the physician often has an opportunity for preventive mental health intervention. Many mothers sense that their children have significant emotional difficulties but fail to bring them out unless the physician inquires. In some instances, these difficulties will be incidental to the patient's main complaint; at other times, they are significantly tied to it. In any event, if the history indicates that a child may have significant emotional problems, this difficulty can often be more easily resolved in childhood than in later years. The primary physician can then encourage early intervention that may prevent more serious difficulties later.

The relationship of older patients with their adult children is also of great importance. Inquire about the fit between the expectations and hopes that the parents have had for their children and actual life events. In cases where children have been a disappointment, many patients will experience considerable guilt.

Emotional ties to relatives—parents, siblings, children, grandparents—are often particularly close. Questions such as, "How do you get along with your parents?" or "What contact do you have now with your relatives?" will often open floodgates of important information. If married patients do not spontaneously mention their relationships with in-laws, specific questions should be asked by the physician, since these relationships, as evidenced by the multitude of mother-in-law jokes, are often sources of conflict.

The complexity of family emotional interrelationships can be seen in the following case:

> An 11-year-old girl had been treated for severe asthma for 5 years with multiple hospitalizations and many different medications. Despite all efforts to help her, the asthma became more and more disabling. Because an emotional component to her illness was suspected, psychotherapy was begun. During the early phases of therapy, the mother revealed that the father was being unfaithful and that he wanted a divorce. The mother opposed the divorce, and the resultant conflict was bitter. The patient's asthmatic attacks and hospitalizations repeatedly occurred in conjunction with major quarrels between parents. After psychotherapy was started, her asthma improved to the point that she required no fur-

ther hospitalizations. Nevertheless, she continued to have intermittent asthmatic attacks until the parents, after a period of separation from each other, finally reconciled. Eventually the parents reestablished a good relationship with each other, and thereafter the patient's asthmatic attacks stopped.

Obviously the fact that the asthma subsided only after the family turmoil was resolved does not prove in a scientific sense that the asthma was caused by stress the patient felt. The patient's psychotherapy covered more than a 3-year period, and other factors, such as the physical changes of adolescence, may have played a part in her recovery. Nevertheless, such cases are seen often enough in practice that most experienced clinicians have little doubt that interpersonal emotional stress can be an important factor in asthma.

Social Relationships

The circumstances in which the patient is living can be explored with direct questions. Information should be sought from unmarried patients about relationships with any persons with whom they share their dwellings. The patient should be asked to describe recreational activities and community involvement. The physician can then lead quite naturally into a discussion of interpersonal relationships. Many people have numerous acquaintances and superficial friends but nonetheless feel quite lonely and isolated in respect to having close friends. The patient can be asked whether the number of friends is as great as desired and whether some are persons to whom the patient can freely confide feelings.

Work Relationships

Since work is an almost universal human experience, it is not surprising that it can be an important source of stress. Gainful employment in American society is so important that its lack is almost always associated with emotional upheaval and loss of self-esteem. One must be particularly careful not to be deceived by a patient's statement that work is a problem-free area. This may be true in the patient's mind, but indirect effects of the occupation on other aspects of life experience may not have been recognized. Many people are so emotionally invested in their work that they fail to see the devastating effects of their long hours and arduous schedule on their family relationships. Physicians are particularly prone to this difficulty.

Beginning inquiry in this area with an open-ended question such as, "Tell me about your work," is usually more productive than asking direct questions that can be answered yes or no. It is advisable to ask for more details if a patient gives only a general statement. For example, a patient who reports working in a chicken plant has not told the physician precisely what the job is. There is a vast difference between the secretary's job in the central office and the job of the person on the production line who removes the intestines. Inquiry into goals is often helpful. Asking about childhood ambitions may lead to a comparison of current status with what the patient would have preferred to become. If a person describes difficulties, either dissatisfaction with advancement, personality clashes, or a failure to see meaning in the work, this area should be explored in as much depth as the patient is willing to pursue.

One should not close inquiry without asking for a specific report of the patient's work schedule. This should include information concerning total hours of work per week, amount of night work, and extent of out-of-town travel. The spouse should also be asked about the work schedule, since many people tend to underestimate the amount of time they are spending at work.

Religious Relationships

Most Americans state some religious preference. More than half of all Americans are affiliated with some church organization, but many Americans have only superficial contact with these religious organizations. Emotional problems revolving around religious conflicts are not as frequent as those arising out of marital or work relationships. Nevertheless, such conflicts occur frequently enough to warrant some investigation of this area.

If a patient indicates no religious belief, additional questions can still be useful. One might ask whether the lack of religious belief creates any problem. The patient's response to this or a similar question will often reveal whether this area is one that should be explored further. Some patients with no religious preference may be choosing this course out of unconscious rebellion toward parents or from some other motivation that they do not fully understand. In these cases, the presence of the apparent conflict can be noted and later explored in more depth. For patients who express a religious preference, inquiry into their church activities can be helpful. As they describe their church contacts, it is usually easy to make an accurate estimate of the significance of religion to them and of the presence of potential conflicts. Asking if religious beliefs cause behavior that is unlike that of most others in the patient's social group or whether religious beliefs cause feelings of being different can also be revealing in terms of bringing emotional difficulties to the surface.

Many people find strong emotional support from their religious convictions. Deep religious conviction is not in itself a sign of emotional difficulty. If a patient's behavior is considerably different from that of most others in the religious group, however, the physician should inquire carefully into reasons for this discrepancy.

Sexual Relationships

Most sexual difficulties are not caused by physical problems. They are usually the result of emotional conflict. Consequently, it is of great importance to explore the feelings which the patient has toward the sexual partner. The procedures for taking a sexual history are outlined in Chapter 216.

Basic Science

Not only has mental illness been found in all cultures that have been carefully studied, but evidence of its existence can be found in the depths of antiquity. There have been many views of the basic cause of mental disturbance, but almost all ancient theories saw it as basically being the result of something amiss within the individual. Many ancient views focused on mental illness as the result of actions of the gods

or infestation of persons by demons. Hippocrates (460–377 B.C.) suggested that madness came from the effect of various forms of bile. From that time to the present, physicians have continued to be fascinated by the effects of physical dysfunction on mental activity. After the demonstration by H. Noguchi of *Treponema pallidum* in the brain of patients with central nervous system syphilis, there could be little question that physical conditions could be the basis of major mental problems. Since that time, many psychiatric conditions have been found to have an organic etiology.

A related but somewhat different line of thought also placed the basic problem of mental illness within the patient but saw this as a problem of organization of thinking rather than as some physical defect in nervous system function. Studies of hypnosis clearly demonstrated that major changes in thinking patterns and behavior could be accomplished purely by the psychological technique of suggestion. Early work in the area of hypnosis by such people as Anton Mesmer (1734–1815), James Braid (1795–1860), Hippolyte Bernheim (1840–1919), and Jean Martin Charcot (1825–1893) illustrated both that the symptoms of certain patients could be altered by suggestions and that the mind could block out awareness of posthypnotic suggestions without in any way diminishing the patient's need to follow the suggestions.

The psychoanalytic studies of Freud, Jung, Adler, and Rank have demonstrated the presence of unconscious motivation for behavior. Clinical investigation into the reasons for unconscious emotional conflicts has repeatedly led to the conclusion that interpersonal relationships play a major role in the development of personality. Relationships with parents have been found to be of particular importance in the development of basic attitudes. Harry Stack Sullivan (1892–1949) utilized astute and accurate clinical observations to focus intensively on the importance of the interpersonal relationships. His emphasis on communication processes in interpersonal behavior laid the groundwork for the present strong emphasis on environment and interpersonal relationships as etiologic factors in many emotional disorders.

The emotional state of the patient is primarily the result of an interaction between his or her internal and external environment. If the internal environment is altered by physical disease such as central nervous system syphilis (general paresis) or Korsakoff's syndrome (an organic brain syndrome caused by vitamin deficiency associated with alcoholism), mental illness can occur. Similarly, a patient overwhelmed by emotional stress may experience derangements in the organization of his or her thinking. Such patients have no demonstrable nervous system lesions that would account for the neurotic or psychotic behavior.

Disruptions in interpersonal relationships are frequently the precipitating events for neurotic and psychotic behavior. Consequently, most modern thinking sees mental illness as an interaction between an internal emotional substrate different for each individual and environmental stresses.

Most forms of psychotherapy focus on both resolution of internal conflicts and improvement in the patient's ability to handle interpersonal relationships. Many psychiatrists view psychotherapy as an educational process that provides increased understanding of self and enhanced ability to deal with interpersonal relationships. Behavior therapy focuses directly on learning the skills needed for improving interpersonal relationships with the operating assumption that the patient's internal mental state will move in the desired direction once the external stresses are resolved.

Clinical Significance

In many cases, inquiry into interpersonal relationships will produce evidence of considerable strength. This information in itself may be of great help in dealing with medical problems. For example, if a strong, harmonious marriage exists, the physician can then count on the patient's spouse to be supportive of the patient during the illness being treated. In some cases in which interpersonal conflicts are present, these conflicts may exist without having any significant relationship to the presenting illness. Nevertheless, identification of these conflicts may make it possible for the patient to be helped by counseling at a later time. In other circumstances, elucidation of the emotional conflict may be the single most important item in the history. Little is gained by treating only physical complaints when these are actually of psychophysiologic origin. In these cases, the solution is found in dealing effectively with the emotional difficulties.

The physician must judge whether emotional conflicts are or are not a significant factor in the presenting complaint. This determination is at times made somewhat by exclusion. When the physician can find no organic etiology for physical complaints, a psychiatric consultation is frequently appropriate. It must be emphasized, however, that psychologic causation for a condition must not be accepted purely on the basis that nothing else can be found. There must also be clear evidence of a psychiatric disorder.

Diagnostic entities in which psychologic factors are often of great importance in the production of physical illness include duodenal ulcer, ulcerative colitis, asthma, neurodermatitis, and essential hypertension.

Surveys of internists and family physicians have indicated that 25 to 50% of the patients whom they see in office practice come with problems that are basically of emotional origin. Some of these problems can be solved by environmental manipulation, such as divorce or changing jobs. Others will require specialized psychiatric intervention.

The physician should not attempt to make decisions for the patient. Rather, patients should be encouraged to explore all alternatives and then make their own decisions. Although the physician should be careful to allow patients to make their own decisions, the physician does have the responsibility of stating clearly to each patient the fact that psychophysiologic symptoms are coming from emotional stress. Without such a statement of the facts, the patients do not have all the information needed to understand their situations fully.

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